

Patier

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**ICANotes**  
Behavioral Health EHR

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Photo

Chart Details **Marquez, James A** **10000107**  
Patient's Name 23 Yrs Patient's ID  
Go to E-Prescribe **DOB 3/16/2000**

**Demographics**

Anaphylactic Reaction Reported ☐ Patient Reviewed Demographics

Patient Information	Insurance Information	Other Contacts
<b>*Name (F,M,L,Suffix)</b> <b>James A Marquez</b>	<b>*Date of Birth</b> <b>3/16/2000</b> Age: <b>23</b>	<b>*Date of Entry</b> <b>7/19/2021</b>
<input checked="" type="checkbox"/> Homeless Address	<b>Unique Patient ID</b> <b>1000010725338</b>	<b>*Sex:</b> <b>M</b> <i>Red fields are required</i>
<input type="checkbox"/> Bad Address Addr 2 / Appt #	<b>*Gender</b> <b>man</b> <a href="#">more</a>	
<input type="checkbox"/> Sample Chart City, State, Zip	<b>Refer to patient as</b> <b>James</b>	
<b>Best Phone</b> Home Phone	<b>SSN #</b> <b>649-20-7243</b>	<b>Extra Privacy</b>
<input type="radio"/> Home Cell Phone	<b>Alt. Patient ID</b>	<b>Room:</b>
<input type="radio"/> Work Work Phone	<b>Other Names</b>	<b>MAR</b> <input type="checkbox"/> <a href="#">API /</a>
<input type="radio"/> Cell ext	<b>Previous Address</b>	
<b>Email</b>		
<b>Email 2</b>		
<b>Portal</b> <input type="checkbox"/>		
<b>Patient Status</b> <input checked="" type="radio"/> Active <input type="radio"/> Inactive <input type="radio"/> Pending	<b>Patient's Condition</b>	
<b>API</b> <input type="checkbox"/>	<b>Date Of Current Illness Onset</b>	<b>Date Of Similar Illness</b>
<b>Appt Reminders via:</b> <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Phone Message	<b>Date of Current Admission: From</b>	<b>To</b>
<b>Employment Status</b>	<b>Admitting DX</b>	
<b>School or Employer</b>	<b>Dates Unable To Work: From</b>	<b>To</b>
<b>Grade</b>	<b>Condition Related To Employment?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No	
<b>Marital Status</b>	<b>Condition Related To Auto Accident?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No	<b>State Of Accident</b>
<b>Sexual Orientation</b>	<b>Condition Related To Other Accident?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No	
<b>*Ethnicity</b>	<b>In treatment Previously?</b> <input type="radio"/> Y <input type="radio"/> N <b>If yes, where?</b>	
<b>Ethnicity 2</b> <a href="#">more</a>	<b>Date Of Death</b>	<b>Preliminary Cause</b>
<b>Religion</b>		
<b>Annual Household Income</b>	<b>Release of Info</b>	<b>Adv. Dir.</b>
<b>Family Size</b>	<b>Patient Calendar Note</b>	<b>Miscellaneous Notes</b>
<b>Veteran</b> <input type="radio"/> Y <input type="radio"/> N		
<b>*Race</b>		
<b>Race 2</b>		
<b>*Preferred Language</b>		
<b>Disability</b>		
		<b>Custom Fields</b>